Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

McALLEN MEDICAL CENTER
3255 WEST PIONEER PARKWAY
ARLINGTON TX 76013

Respondent Name

INDEMNITY INSURANCE CO OF NORTH AMERICA

Carrier's Austin Representative Box

Box Number 15

MFDR Date Received

SEPTEMBER 13, 2007

MFDR Tracking Number

M4-08-0851-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary dated August 15, 2007: "Per the ACIHFG, claims with charges over $40,000 are to be payable at 75% of charges."

Amount in Dispute: $27,202.43

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary dated October 22, 2007: "McAllen is not entitled to reimbursement under the stop-loss exception to DWC Rule 134.401. Under Rule 134.401, reimbursement is generally to be provided at a per diem rate. There are some exceptions to that. One of those exceptions is the stop-loss exception. DWC Rule 134.401(3)(c) contains the stop-loss exception. It explains the stop-loss exception is to be utilized in unusually costly or unusually extensive services. There have been no documents provided establishing that the services at issue in this case were unusually costly or extensive. Additionally, the stop-loss exception only applies to those cases where the total audited charges exceed the $40,000.00 minimum stop-loss threshold. In this case, the audited charges failed to exceed that $40,000.00 minimum threshold and the stop-loss exception should not apply…Accordingly, Broadspire appropriately reimbursed the provider." "Additionally, the reimbursement being requested by the provider fails to comply with Section 413.011."

Response Submitted by: Burns, Anderson, Jury & Brenner, L.L.P., P.O. Box 26300, Austin, TX 78755-6300

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
September 10, 2006 through September 15, 2006	Inpatient Services	$27,202.43	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.308 sets out the procedures for requesting review by an Independent Review Organization (IRO).
4. 28 Texas Administrative Code §134.401 sets out the fee guideline for acute care inpatient hospital services.
5. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
6. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1-Workers compensation state fee schedule adjustment.
   - 45-Charges exceed your contracted/legislated fee arrangement.
   - 50-These are non-covered services because this is not deemed a 'medical necessity' by the payer.
   - 107-Claim/service adjusted because the related or qualifying claim/service was not identified on this claim.
   - 167-This (These) diagnosis (es) is (are) not covered.
   - 861-It appears that injury/illness may not be WC related. Further information required to properly evaluate.
   - 873-Reimbursement not recommended; service(s), item(s), not medically necessary for remedial treatment of the work related injury/illness.
   - 885-999-Review of this code has resulted in an adjusted reimbursement.
   - 893-001-Upon further review, additional payment is warranted.
   - 893-Late charges disallowed as original billing repriced according to per diem rate.
   - 900-Based on further review, no additional allowance is warranted.
   - 958-100-Late charges/additional charges reviewed.
   - 975-410-Copy of provider's invoice used to determine reimbursable amount.
   - 975-640-Nurse review in-patient hospital/facility/supply house.
   - 147-Provider contracted/negotiated rate expired or not on file.
   - W4-No additional reimbursement allowed after review of appeal/reconsideration.

Findings

1. According to the explanation of benefits, the carrier paid the services in dispute in accordance with a contracted or legislated fee arrangement. The PPO/Network Discount amount on the submitted explanation of benefits denotes a "0.00" discount. The Division finds that documentation does not support that the services were discounted due to a contract; therefore, reimbursement for the services will be reviewed in accordance with applicable division rules and guidelines.
2. According to the explanation of benefits, the carrier denied reimbursement for revenue codes 480-Cardiology at $1,887.00, 750-Gastr-ints svs at $3,050.00, and 921-Pervivasul lab at $1,464.00 based upon" 50-These are non-covered services because this is not deemed a 'medical necessity' by the payer".

   28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." 28 Texas Administrative Code §133.307(e)(3)(G) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General). The appropriate dispute process for unresolved issues of medical necessity requires the filing of a request for review by an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. Review of the submitted documentation finds that there are unresolved issues of medical necessity for the same service(s) for which there is a medical fee dispute. No documentation was submitted to support that the issue(s) of medical necessity have been resolved prior to the filing of the request for medical fee dispute resolution.

   The requestor has failed to support that the charges/services denied based upon medical necessity are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307. Therefore, these charges/services will not be considered further.

3. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 820.21.
4. The requestor asks for reimbursement under the stop loss provision of the Division's *Acute Care Inpatient Hospital Fee Guideline* found in Division rule at 28 TAC §134.401(c)(6). The requestor asserts in the position statement that "Per the ACIHFG, claims with charges over $40,000 are to be payable at 75% of charges". 28 Texas Administrative Code §134.401(c)(6), effective August 1, 1997, 22 TexReg 6264, states, in part, that "The diagnosis codes specified in paragraph (5) of this subsection are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate." As stated above, the Division has found that the primary diagnosis is a code specified in Division rule at 28 TAC §134.401(c)(5); therefore, the disputed services are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 TAC §134.1.
5. Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
6. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
7. 28 Texas Administrative Code §133.307(c)(2)(G), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
   - The requestor's position statement asserts that "Per the ACIHFG, claims with charges over $40,000 are to be payable at 75% of charges."
   - The requestor does not discuss or explain how additional payment of $27,202.43 would result in a fair and reasonable reimbursement.
   - The requestor seeks reimbursement for this admission based upon the stop-loss reimbursement methodology which is not applicable per Texas Administrative Code §134.401(c)(6).
   - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
   - The Division has previously found that a reimbursement methodology based upon payment of a hospital's billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 Texas Register 6276 (July 4, 1997) that:

     "A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources."
   - The requestor did not discuss or support that the proposed methodology would ensure that similar procedures provided in similar circumstances receive similar reimbursement.
   - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

		12/12/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.